



Handbook for Providers of Therapy Services

Chapter J-200 Policy and Procedures for Therapy Services

Illinois Department of Public Aid

CHAPTER J-200

THERAPY SERVICES

TABLE OF CONTENTS

FOREWORD

J-200 BASIC PROVISIONS

J-201 PROVIDER PARTICIPATION

- .1 Participation Requirements
- .2 Participation Approval
- .3 Participation Denial
- .4 Provider File Maintenance

J-202 REIMBURSEMENT

- .1 Charges
- .2 Electronic Claims Submittal
- .3 Claim Preparation and Submittal
 - .1 Claim Submittal
- .4 Payment
- .5 Fee Schedule

J-203 COVERED SERVICES

- .1 Occupational Therapy
- .2 Physical Therapy
- .3 Speech and Language Therapy
- .4 Therapy Services Provided in a Hospital Setting

J-204 SERVICES NOT COVERED

J-205 RECORD REQUIREMENTS

J-211 PRIOR APPROVAL PROCESS

- .1 Prior Approval Requests
- .2 Post Approvals

APPENDICES

- J-1 Claim Preparation and Mailing Instructions - Form DPA1443, Provider Invoice**
- J-1a Facsimile of Form DPA1443, Provider Invoice**
- J-1b Claim Preparation and Mailing Instructions - Medicare/Medicaid Combination Claims**
- J-2 Preparation and Mailing Instructions for Form DPA 1409, Prior Approval Request**
- J-2a Facsimile of Form DPA 1409, Prior Approval Request**
- J-3 Explanation of Information on Provider Information Sheet**
- J-3a Facsimile of Provider Information Sheet**
- =J-4 Initial Treatment without Prior Approval for Physical and Occupational Therapy**
- =J-5 Guidelines for Service Not Requiring Prior Approval for Speech and Language Therapy**

FOREWORD

PURPOSE

This handbook has been prepared for the information and guidance of therapy services providers who provide items or services to participants in the Department's Medical Programs. This handbook provides information on which services require prior approval and how to obtain prior approval.

This handbook can be viewed on the Department's website at

<http://www.state.il.us/dpa/handbooks.htm>

This handbook provides information regarding specific policies and procedures relating to therapy services.

It is important that both the provider of service and the provider's billing personnel read all materials prior to initiating services to ensure a thorough understanding of the Department's Medical Programs policy and billing procedures. Revisions in and supplements to the handbook will be released from time to time as operating experience and state or federal regulations require policy and procedure changes in the Department's Medical Programs. The updates will be posted to the Department's website at

http://www.state.il.us/dpa/medical_programs.htm

Providers will be held responsible for compliance with all policy and procedures contained herein.

Inquiries regarding coverage of a particular service or billing issues may be directed to the Bureau of Comprehensive Health Services at 217-782-5565.

CHAPTER J-200

THERAPY SERVICES

J-200 BASIC PROVISIONS

For consideration for payment by the Department for therapy services, such items or services must be provided by a provider enrolled for participation in the Department's Medical Programs. The items or services must be provided in full compliance with both the general provisions contained in the Handbook for Providers of Medical Services, General Policy and Procedures (Chapter 100) and the policy and procedure contained in this handbook. Exclusions and limitations are identified in the specific topics contained herein.

J-201 PROVIDER PARTICIPATION

J-201.1 PARTICIPATION REQUIREMENTS

Therapy services providers must meet one of the following criteria to be considered for enrollment to participate in the Department's Medical Programs.

- A Physical Therapist who is licensed by the Illinois Department of Professional Regulation and/or licensed in their state of practice.
- An Occupational Therapist who is licensed by the Illinois Department of Professional Regulation and/or licensed in their state of practice.
- A speech-language pathologist (SLP) who is licensed by the Illinois Department of Professional Regulation and/or licensed in their state of practice, or has completed the academic requirements and is in the process of accumulating the necessary supervised work experience required for licensure.

The provider must be enrolled for the specific category of services for which charges are to be made. The categories of service for which a therapy provider may enroll are:

COS	SERVICE DEFINITION
11	Physical Therapy Services
12	Occupational Therapy Services
13	Speech Therapy/Pathology Services

Procedure: The provider must complete and submit:

- Form DPA 2243 (Provider Enrollment/Application)
- Form DPA 1413 (Agreement for Participation)
- HCFA 1513 (Disclosure of ownership and controlling interest)
- W9 (Request for Taxpayer Identification Number)

These forms may be obtained from the Provider Participation Unit. E-mail requests for enrollment forms should be addressed to:

PPU@mail.idpa.state.il.us

Providers may also call the unit at (217)782-0538 or mail a request to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

The forms must be completed (**printed** in ink or typewritten), signed and dated in ink by the provider, and returned to the above address. The provider should retain a copy of the forms. The date on the application will be the effective date of enrollment unless the provider requests a specific enrollment date and it is approved by the Department.

Participation approval is not transferable - When there is a change in ownership, location, name, or a change in the Federal Employer's Identification Number, a new application for participation must be completed. Claims submitted by the new owner using the prior owner's assigned provider number may result in recoupment of payments and other sanctions.

J-201.2 PARTICIPATION APPROVAL

When participation is approved, the provider will receive a computer-generated notification, the Provider Information Sheet, listing all data on the Department's computer files. The provider is to review this information for accuracy immediately upon receipt. For an explanation of the entries on the form, see Appendix J-3.

If all information is correct, the provider is to retain the Provider Information Sheet for subsequent use in completing claims (billing statements) to ensure that all identifying information required is an exact match to that in the Department files. If any of the information is incorrect, refer to Topic J-201.4.

J-201.3 PARTICIPATION DENIAL

When participation is denied, the provider will receive written notification of the reason for denial.

Within ten calendar days after this notice, the provider may request a hearing. The request must be in writing and must contain a brief statement of the basis upon which the Department's action is being challenged. If such a request is not received within ten calendar days, or is received, but later withdrawn, the Department's decision shall be a final and binding administrative determination. Department rules concerning the basis for denial of participation are set out in 89 Ill. Adm. Code 140.14. Department rules concerning the administrative hearing process are set out in 89 Ill. Adm. Code 104 Subpart C.

J-201.4 PROVIDER FILE MAINTENANCE

The information carried in the Department's files for participating providers must be maintained on a current basis. The provider and the Department share responsibility for keeping the file updated.

Provider Responsibility

The information contained on the Provider Information Sheet is the same as in the Department's files. Each time the provider receives a Provider Information Sheet, it is to be reviewed carefully for accuracy. The Provider Information Sheet contains information to be used by the provider in the preparation of claims; any inaccuracies found are to be corrected and the Department notified immediately.

Any time the provider effects a change that causes information on the Provider Information Sheet to become invalid, the Department is to be notified. When possible, notification should be made in advance of a change..

Procedure: The provider is to line out the incorrect or changed data, enter the correct data and sign the Provider Information Sheet with an original signature on the line provided. Forward the corrected Provider Information Sheet to:

Illinois Department of Public Aid
Provider Participation Unit
Post Office Box 19114
Springfield, Illinois 62794-9114

Failure of the provider to properly notify the Department of corrections or changes may cause an interruption in participation and payments.

Department Responsibility

When there is a change in a provider's enrollment status or a change is submitted by the provider, the Department will generate an updated Provider Information Sheet reflecting the change and the effective date of the change. The updated sheet will be sent to the provider and to any payees listed if the address is different from the provider.

J-202 REIMBURSEMENT

When billing for services or materials, the claim submitted for payment must include a diagnosis and the coding must reflect the actual services provided. Any payment received from a third-party payer, a program participant or other persons applicable to the provision of services must be reflected as a credit on any claim submitted to the Department bearing charges for those services or items. (Exception: Department co-payments are not to be reflected on the claim. Refer to Topic 114.1 for more information on patient cost-sharing.)

J-202.1 CHARGES

Charges billed to the Department must be the provider's usual and customary charge billed to the general public for the same service or item. Providers may only bill the Department **after** the service or item has been provided.

A provider may only charge for services he or she personally provides. Providers may not charge for services provided by another provider, even though one may be in the employ of the other.

Charges for services and items provided to participants enrolled in a Managed Care Organization (MCO) must be billed to the MCO according to the contractual agreement with the MCO.

J-202.2 ELECTRONIC CLAIMS SUBMITTAL

Any services which do not require attachments or accompanying documentation may be billed electronically. Further information can be found in Chapter 100, Topic 112.3.

Providers billing electronically should take special note of the requirement that Form DPA 194-M-C, Billing Certification Form, must be signed and retained for a period of three years from the date of the voucher. Failure to do so may result in revocation of the provider's right to bill electronically, recovery of monies or other adverse actions. Form DPA 194-M-C can be found on the last page of each Remittance Advice which reports the disposition of any electronic claims. Refer to Chapter 100, Topic 130.5 for further details.

The specifications for electronic claims billing are similar to, but not the same as, those for paper claims. Please follow the instructions for the media being used. If a problem occurs with electronic billing, the provider should contact the Department in the same manner as would be applicable to a paper claim. It may be necessary for the provider to contact his software vendor if the Department determines that the claim rejections are being caused by the submission of incorrect or invalid data.

J-202.3 CLAIM PREPARATION AND SUBMITTAL

Refer to Chapter 100, Topic 112, for general policy and procedures regarding claim submittal. For general information on billing for Medicare covered services and submittal of claims for participants eligible for Medicare Part B, refer to Chapter 100, Topics 112.5 and 120.1. For specific instructions for preparing claims for Medicare covered services, refer to Appendix J-1b.

The Department uses a claim imaging system for scanning paper claims. The imaging system allows more efficient processing of paper claims and also allows attachments to be scanned. Refer to Appendix J-1 for technical guidelines to assist in preparing paper claims for processing. The Department offers a claim scannability/imaging evaluation. Please send sample claims with a request for evaluation to the following address.

Illinois Department of Public Aid 201 South Grand Avenue East Second Floor - Data Preparation Unit Springfield, Illinois 62763-0001 Attention: Vendor/Scanner Liaison

J-202.31 Claims Submittal

Form DPA 1443, Provider Invoice, is to be used to submit charges. A copy of the form and detailed instructions for its completion are included in Appendices J-1 and J-1a.

All routine paper claims are to be submitted in a pre-addressed mailing envelope provided by the Department for this purpose, DPA 1444, Provider Invoice Envelope. Use of the pre-addressed envelope should ensure that billing statements arrive in their original condition and are properly routed for processing.

For a non-routine claim, use Form DPA 2248, Special Handling Envelope. A non-routine claim is:

- Any claim to which Form DPA 1411, Temporary MediPlan Card, is attached.
- Any claim to which any other document is attached.

For electronic claims submittal, Refer to Topic J-202.2 above. Non-routine claims may not be electronically submitted.

J-202.4 PAYMENT

Payment made by the Department for allowable services will be made at the lower of the provider's usual and customary charge or the maximum rate as established by the Department. Refer to Chapter 100, Topics 130 and 132, for payment procedures utilized by the Department and General Appendix 8 for explanations of Remittance Advice detail provided to providers.

J-202.5 FEE SCHEDULE

The Department's maximum reimbursement rates for the allowable procedures are listed on the Department's website. The listing can be found at

<http://www.state.il.us/dpa/html/medicaidreimbursement.htm>

Paper copies of the listing can be obtained by sending a written request to:

Illinois Department of Public Aid
Bureau of Comprehensive Health Services
201 South Grand Avenue East
Springfield, IL 62763-0001

The website listings are updated annually. Providers will be advised of major changes via a written notice. Provider notices will not be mailed for minor updates such as error corrections or the addition of newly created HCPCS or CPT codes.

J-203 COVERED SERVICES

A covered service is a service for which payment can be made by the Department. Refer to Chapter 100, Topic 103, for a general list of covered services. A physician's order must be on file and services must be provided in accordance with a definite plan of care established by the therapist, for the purpose of attaining maximum reduction of a physical disability and/or restoration of the individual to an acceptable functional level.

Services and materials are covered only when provided in accordance with the limitations and requirements described in the individual topics within this handbook.

J-203.1 OCCUPATIONAL THERAPY

Covered Occupational Therapy services include medically necessary evaluations and treatment by a licensed Occupational Therapist when: a) services are required because an illness, disability or infirmity limits functional performance; and b) Occupational Therapy services will improve functional skills performance.

Covered services include, but are not limited to, activities of daily living, when Occupational Therapy services will increase independence and/or decrease the need for other support services.

Services must be provided in accordance with a definite plan of care established by the therapist, for the purpose of attaining maximum reduction of a physical disability and restoration of the client to an acceptable functional level.

J-203.2 PHYSICAL THERAPY

Covered Physical Therapy services include medically necessary evaluations and treatment by a licensed Physical Therapist when: a) services are required because an illness, disability or infirmity limits functional performance; and b) Physical Therapy services will improve functional skills performance.

Covered services include, but are not limited to, activities of daily living, when Physical Therapy services will increase independence and/or decrease need for other support services.

J-203.3 SPEECH AND LANGUAGE THERAPY

Speech and language therapy are covered services when provided according to established program guidelines and with prior approval as appropriate.

Services must be provided in accordance with a definite plan of care established by the therapist, for the purpose of attaining maximum reduction of a physical disability and restoration of the client to an acceptable functional level.

J.203.4 THERAPY SERVICES PROVIDED IN A HOSPITAL SETTING

Physical therapy provided by a salaried therapist in an outpatient or hospital based clinic setting does not require prior approval. Such services, will be billed in compliance with the instructions contained in the Hospital Handbook.

Physical Therapy provided by a nonsalaried therapist in an outpatient or hospital based clinic setting must be in compliance with the instructions contained in this handbook.

Occupational and Speech Therapy services provided by a salaried therapist must be billed on the DPA 1443 under the hospital's name and number. Prior approval may be required depending upon the code(s) utilized when billing.

J-204 SERVICES NOT COVERED

Services for which medical necessity is not clearly established are not covered by the Department's Medical Programs. The objective of the Department's Medical Programs is to enable eligible participants to obtain necessary medical care.

"Necessary medical care" is that which is generally recognized as standard medical care required because of disease, disability, infirmity or impairment. Refer to Chapter 100, Topic 104, for a general list of non-covered services.

Services provided for the general good and welfare of clients, such as fitness exercises and activities to provide diversion or general motivation, are not covered.

Therapy services are not covered for participants in the Transitional Assistance Program and for adult participants in the Family and Children Assistance Program in the City of Chicago.

J-205 RECORD REQUIREMENTS

The Department regards the maintenance of adequate records as essential for the delivery of quality medical care. In addition, providers should be aware that medical records are key documents for post-payment audits. Refer to Chapter 100, Topic 110 for record requirements applicable to all providers.

For therapy services, the basic record must include:

- Current physician's order
- Clinical diagnoses, if not included in the physician's order
- Patient's name, recipient identification number (RIN) and address
- Initial assessment and treatment plan
- Progress reports, and
- Approved prior authorization requests, if applicable.

In the absence of proper and complete medical records, no payment will be made and payments previously made will be recouped. Lack of records or falsification of records may also be cause for a referral to the appropriate law enforcement agency for further action.

J-211 PRIOR APPROVAL PROCESS

Prior to the provision of certain services approval must be obtained from the Department.

If charges are submitted for services which require prior approval and approval was not obtained, payment will not be made for services as billed. See Chapter 100, Topic 111, for a general discussion of prior approval provisions.

The Department will not give prior approval for an item or service if a less expensive item or service is considered appropriate to meet the patient's need.

Prior approval to provide services does not include any determination of the patient's eligibility. When prior approval is given, it is the provider's responsibility to verify the patient's eligibility on the date of service.

Prior approval requirements do not apply in situations in which physical, occupational and speech therapy services are provided:

- to an individual within a sixty-calender day period immediately following discharge from an acute care or a rehabilitation hospital;
- to an individual eligible for Medicare Part B benefits and the service is covered by the Medicare Program;
- the individual has been hospitalized within the past thirty days and was, while hospitalized, receiving therapy services;
- to children age 0-20;
- = • for the intial evaluation and treatment period as described in Appendices J-4 and J-5

Prior approval is required for continuation of therapy after the initial sixty-day period. It is the responsibility of the provider to initiate the request as soon as possible within the first sixty days in order to avoid disruption of services.

Procedure: The provider is to complete and submit Form DPA 1409, Prior Approval Request. A copy of the physician orders and a copy of the initial evaluation or progress summary are required attachments. The length of time of sessions should be noted.

Prior Approval requirements are waived in instances in which Medicare payment is approved. If the service is noncovered, determined not medically necessary by Medicare, or when Medicare benefits are exhausted, post approval from the Department is required.

Procedure: The provider is to submit the adjudicated Medicare billing form, Explanation of Medicare Benefits, and completed Form DPA 1409. Approval will be granted when in the judgement of a consulting physician and/or professional staff of the Department; the services are medically necessary and appropriate to meet the individual's medical needs.

J-211.1 PRIOR APPROVAL REQUESTS

Prior approval requests must contain enough information for Department staff to make a well-informed decision on medical necessity, appropriateness and anticipated patient benefits of the service. When it is necessary to provide an item or service outside of routine business hours, refer to Chapter 100, Topic 111.

The single most common reason for denial of prior approval requests is lack of adequate information upon which to make an informed decision.

Prior approval requests may be submitted to the Department by mail, fax, telephone or electronically via the REV system.

By Mail:

The provider is to complete form DPA 1409, Prior Approval Request, when requesting covered services. A sample copy of form DPA 1409 and instructions for its completion are found in Appendices J-2 and J-2a.

All forms DPA 1409 must be signed in ink by the supplying provider or his or her designee. The form DPA 1409 must be accompanied by a current signed and dated physician order for the services requested. Submitting the physician order and other necessary information and explanation of medical necessity when the initial request is made will prevent delays in processing prior approval.

By FAX:

Prior approval may be requested by fax. Complete Form DPA1409, following the procedures described above for mailed requests. The completed form, the physician order and other associated documents can be faxed to the number shown below. Providers should review the documents before faxing to ensure that they will be legible upon receipt.

The fax number for prior approval requests is 217-524-0099. This fax is available 24 hours a day. Requests faxed during non-business hours will be considered to have been received on the next normal business day.

By Telephone:

When prior approval is requested by telephone, the request will be data entered by staff at one of the following telephone numbers:

217-785-6239
217-524-0005
217-524-7354
217-524-7357

These numbers are available Monday through Friday, 8:30 AM to 5:00 PM, excepting holidays.

The caller must be prepared to give all the information requested on the DPA 1409.

The provider is responsible for having a valid physician order and statement of medical necessity which bears the ordering physician's signature at the time of the request. The Department reserves the right to request proof of documentation before approval is granted.

Electronically:

Prior approval requests may be electronically submitted into the Department's prior approval system by the provider via any of the Department's approved Recipient Eligibility Verification (REV) vendors. For more information on the REV system, refer to Handbook for Providers of Medical Services, Chapter 100 General Policies and Procedures, Topic 131.2. For a listing of approved REV vendors, refer to http://www.state.il.us/dpa/html/medical_rev.htm

If the provider is mailing or faxing the physician order or other medical documentation in support of an electronically-submitted request, this information should be noted in the comments section of the electronic request. In addition, the mailed or faxed materials should clearly indicate that the prior approval request has been electronically submitted. Failure to make these notations will make it more difficult for the Department to match the documentation with the prior approval request and thus may delay a decision on the request.

The Department reserves the right to request proof of a valid physician order or other supporting documentation before approval is granted.

J-211.2 POST APPROVALS

Post approval may be requested. Post approval may be granted upon consideration of individual circumstances, such as:

- Determination of the patient's eligibility for the Medical Assistance Program or for KidCare was delayed or approval of the application had not been issued as of the date of service. In such a case, the post approval request must be received no later than 90 days following the Department's Notice of Decision approving the patient's application.
- There was a reasonable expectation that other third party resources would cover the item and those third parties denied payment after the item was supplied. To be considered under this exception, documentation that the provider billed a third party payor within six months following the date of service, as well as a copy of the denial from that third party must be supplied with the request for approval. The request for post approval must be received no later than 90 days from the date of final adjudication by the third party.
- The patient did not inform the provider of his or her eligibility for Medical Assistance or KidCare. In such a case, the post approval request must be received no later than six months following the date of service to be considered for payment. To be considered under this exception, documentation of the provider's dated, private-pay bills or collection correspondence, that were addressed and mailed to the patient each month following the date of service, must be supplied with the request for approval.

To be eligible for post approval consideration, all the normal requirements for prior approval must be met and the post approval requests must be received by the Department no later than 90 days from the date services or items are provided or within the time frames identified above.